STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155505	A. BUILDING 00 B. WING	12/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROBIN RUN HEALTH CENTER	6370 ROBIN RUN W INDIANAPOLIS, IN 46268

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F000000	This visit was for a Recertification and State Licensure Survey. Survey dates: December 12, 13, 16, 17, 18, and 19, 2013. Facility number: 001156 Provider number: 155505 AIM number: 100453350 Survey team: Lora Brettnacher, RN-TC Jeanna King, RN Census bed type: SNF: 19 SNF/NF: 59 Total: 78 Census payor type: Medicare: 11 Medicaid: 44 Other: 23 Total: 78 These deficiencies reflect sate findings cited in accordance with 410 IAC 16.2. Quality review completed 12/26/2013 by Brenda Marshall Nunan, RN.	F000000	The following is the Plan of Correction for Robin Run Health Center regarding the Statement of Deficiencies dated 12/19/2013. This Plan of Correction is not to be construed as an admission of or agreement with the findings and conclusions in the Statement of Deficiencies, or any related sanction or fine. Rather, it is submitted as confirmation of our ongoing efforts to comply with statutory and regulatory requirements. In this document, we have outlined specific actions in response to identified issues. We have not provided a detailed response to each allegation or finding, nor have we identified mitigating factors. We remain committed to the delivery of quality health care services and will continue to make changes and improvement to satisfy that objective. This provider respectfully requests that this 2567 Plan of Correction be considered the Letter of Credible Allegation of Compliance and requests a Post Survey Review on or after January 18, 2014.	
F000241	483.15(a)			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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SS=E	DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. Based on observation, record review, and interview, the facility failed to provide care to residents in a dignified and respectful way by failing to knock on doors and request permission to enter, and by failing to respond or delayed responses to residents' request for assistance. This deficient practice affected 3 of 40 residents reviewed for dignity (Resident #16, Resident #90, and Resident #18). Findings include: 1. During constant observation on 12/12/13 between 11:45 A.M. and 12:20 P.M., At 11:45 P.M., Resident #18 was seated at the side of her bed attempting to pull up her pants. Resident #18 pushed her call light for assistance at 11:45 A.M. Thirty five minutes passed before, CNA [Certified Nursing Assistant] #7 responded to the call light. During an interview on 12/12/2013 at 12:04 P.M., Resident #18 indicated call light waits were too long.	F000241	Dignity & Respect of IndividualityIt is the practice of the provider to promote care in a manner and in an environment that maintains and enhances each resident's dignity and respect in full recognition of his or her individuality.What corrective actions will be accomplished for those residents found to have been affected by the deficient practice:Staff were re-educated on call light response standards for Resident #90, privacy standards for Residents # 90 and #16, promoting respect and dignity for Resident #90 and assisting with transportation when indicated/requested for Resident # 16. Resident #18 has discharged from the facility. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action (s) will be taken:Staff were re-educated on call light response standards, privacy standards, promotion of dignity and respect, and responding with timely assist to expressed/identified resident needs. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does	01/18/2014

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	2. During an observation on 12/13/2013 at 10:17 A.M., CNA #6 was observed to enter Resident #90's room without knocking. CNA #6 left the room after caring for Resident #90's roommate and returned a few minutes later. CNA #6 knocked and immediately entered Resident #90's room without waiting for her permission to enter the room. During an interview on 12/13/2013 at 10:17 A.M., Resident #90 indicated staff did not always treat her with respect and dignity. She stated, "...when she would come in to wash me she would not pull the curtain around so no one could see me. Her attitude was... like she was the one paying me and not me paying to live here. They talked to her.. they claim they are short on help a lot...I had waited 40 minutes to get my wet pants changed which had urine in them. [Assistant Director of Nursing named] started in and [CNA #6 named] stood there and augured with me about the time. I am not stupid. If I got my light on they turn that light off. Nurses too. I don't even have enough time to say please don't turn my light off until I got help...I am supposed to put my light on so I am not lying in my urine... I don't expect immediate but I do expect it before 30 minutes..." During an interview on 12/13/2013 at		not recur:Staff were re-educated on call light response standards, privacy standards, promotion of dignity and respect, and responding with timely assist to expressed/identified resident needs.How corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:A dignity and respect Quality Assurance Performance Improvement audit tool will be utilized weekly times 4 weeks, then bi-weekly times 4 weeks and then monthly until the alleged deficient practice does not recur. The Quality Assurance Performance Improvement audits, as well as the Resident Council Minutes will be reviewed in the monthly Quality Assurance Performance Improvement meeting by the Quality Assurance Performance Improvementcommittee.	

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	10:19 A.M., CNA #6 indicated as long as she knocked she could enter a resident's room. She did not have to wait for them to respond. 3. During an observation on 12/13/2013 at 1:38 P.M., Certified Nursing Assistant [CNA] #2 was observed to enter Resident #16 's room. CNA #2 failed to knock prior to entering Resident #16's room. During an observation on 12/16/2013 at 12:36 P.M., Resident #16 was observed in her wheelchair in front of the nurse's station. Resident #16 asked CNA #3 to help her wheel herself to her room. CNA #3 failed to acknowledge Resident #16's request and walked away. Resident #16 was observed to ask housekeeper staff #4 if she would help her back to her room. Housekeeper #4 stated, "No, I don't think I can do that." Resident #16's record was reviewed on 12/16/2013 at 9:40 A.M. Resident #16 had diagnoses which included, but were not limited to congestive heart failure, anemia, and diabetes. A care plan dated 11/4/2013, indicated Resident #16 tired easily and staff were to provide support as needed with transportation to and from activities.			

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	An annual [MDS] Minimum Data Set Assessment tool dated 10/31/13, indicated Resident #16 utilized a wheel chair for transportation and required extensive physical assistance of one staff for transportation to and from activities such as dining. During an interview on 12/18/2013 at 10:24 A.M., CNA #5 indicated Resident #16 could propel herself in her wheel chair but sometimes she would ask for help if she was too tired. She indicated they should help her if she needed the help. Review of Resident Council minutes dated 5/23/2013, indicated residents expressed concerns regarding, "...CNA and nursing have I don't care attitude about quality of care...." Review of Resident Council minutes dated 7/25/2013, indicated residents expressed concerns with staff not telling them their names prior to providing care, "...CNAs being rude... call lights not answered timely... staff are disrespectful and are not available for assistance...." Review of Resident Council minutes dated 8/29/2013, indicated, "...CNA service issues continue to be concern-specific concerns were issues of			

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	courtesy..." Review of Resident Council minutes dated 9/19/13, indicated, "...continued concern about CNA service consistency...CNA service-politeness and answering call lights viewed as inconsistent...." Review of Resident Council minutes dated 10/17/2013, indicated, "...timeliness of call lights inconsistent. At times prolonged...." Review of Resident Council minutes dated 11/20/17, indicated, "...answering call lights still of concern. Also, service professionalism is inconsistent. Some workers are kind-others are not..." During an interview on 12/19/2013 at 10:30 A.M., the administrator indicated the facility had provided on going inservices in response to the residents complaints of staff attitudes and prolonged call light answer times. She indicated it was her expectation staff should always treat residents with respect and dignity and respond to their calls for assistance promptly and respectfully. 3.1-3(t)			

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F000242 SS=E	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. Based on observation, record review, and interview, the facility failed to ensure residents were given an opportunity to make choices regarding their care. This deficient practice affected 3 of 8 residents reviewed for choices (Resident #18, Resident #90, and Resident #39). Findings include: 1. During an observation on 12/13/2013 at 10:51 AM., CNA [Certified Nursing Assistant] #6 was observed to enter Resident #90's room, hand Resident #90 a cup of water, and ask her if she needed anything. Resident #90's record was reviewed on 12/18/2013 at 9:40 A.M. A quarterly MDS [Minimum Data Assessment Tool] dated 10/31/2013, indicated Resident #90's cognitive status was intact with a BIMS [brief interview mental status assessment tool] score of 15 out of 15.	F000242	Self Determination-Right to Make ChoicesIt is the practice of the provider to promote the right of the resident to make choices about aspects of his or her life in the facility that are significant to the resident. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice:Resident #90 and #39 were interviewed regarding bathing preferences and reasonable individualized accommodations have been made.Resident #90 has been interviewed regarding caregiver preferences and reasonable accommodations have been made.Resident #18 has discharged from the facility. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action (s) will be taken:Cognitively intact residents have been interviewed regarding bathing preferences and reasonable individualized accommodations have been made. How measures	01/18/2014

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	During an interview on 12/13/2013 at 10:51 A.M., Resident #90 indicated she had complained about CNA #6 being rude and disrespectful to her and had requested she not be assigned to care for her anymore. She indicated her son had called and requested the same but the facility had not honored her request. During an interview on 12/13/2013 at 10:51 A.M., CNA [Certified Nursing Assistant] #6 indicated she was assigned to Resident #90. During an interview on 12/17/2013 at 1:57 P.M., with the Administrator and ADON present, the ADON indicated a week ago Resident #90 requested CNA #6 not be assigned to her. The ADON indicated she removed CNA #6 from Resident #90's assignment for the rest of the day but allowed her to care for her after that day. 2. Resident #39's record was reviewed on 12/18/2013 at 9:50 A.M. An annual MDS dated 10/1/2013, indicated Resident #39's cognitive status was intact with a BIMS score of 13 out of 15. During an interview on 12/13/2013 at 2:07 P.M., Resident #39 indicated he did not have a choice regarding his shower schedule. He indicated his shower		will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur:Residents will be interviewed per the comprehensive care plan schedule about aspects of life in the facility that are significant to the individual and reasonable individualized accommodations will be made. How the corrective action(s) will be monitored to ensure deficient practice will not recur, i.e., what quality assurance programs will be put into place.A self-determination Quality Assurance Performance Improvement audit tool will be utilized weekly times 4 weeks, then bi-weekly times 4 weeks, and then monthly until the alleged deficient practice does not recur. The Quality Assurance Performance Improvement audits will be reviewed in the monthly Quality Assurance Performance Improvement meetings by the Quality Assurance Performance Improvementcommittee.	

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	schedule was decided for him by the staff. 3. Resident #18's record was reviewed on 12/18/2013 at 9:21 A.M. A thirty day scheduled MDS dated 11/18/13, indicted Resident #18's cognitive status was intact with a BIMS score of 15 out of 15. During an interview on 12/12/2013 at 11:54 A.M., Resident #18 indicated she was not allowed to choose her bathing schedule. She stated, "... I take a shower once a week. I have either Tuesday or Thursday. I would like to take one whenever I wanted. I tell them and they tell me my shower night is on Tuesday or Thursday. I would like to take three showers a week depending on how I feel." During an interview on 12/17/2013 at 2:30 P.M., the Administrator indicated unless a resident complained the facility did not have a system to ensure residents who resided in the facility were allowed to make choices regarding their bathing schedules. 3.1-3(u)(1) 3.1-3(u)(3)			

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F000247 SS=D	483.15(e)(2) RIGHT TO NOTICE BEFORE ROOM/ROOMMATE CHANGE A resident has the right to receive notice before the resident's room or roommate in the facility is changed. Based on record review and interview, the facility failed to ensure residents were given notice prior to a roommate change for 1 of 8 residents reviewed for notices prior to change in room or roommate (Resident #90). Findings include: Resident #90's record was reviewed on 12/17/13 at 11:00 A.M. Resident #90 had diagnoses which included, but were not limited to, anemia and hypertension. A quarterly MDS [Minimum Data Set Assessment Tool] dated 10/31/13, indicated Resident #90 had no cognitive impairment with a BIMS [brief interview mental status] score of 15 out of 15.	F000247	Right to Notice Before Room/Roommate ChangeIt is the practice of the provider to notify residents before the room or roommate in the facility is changed.What corrective actions will be accomplished for those residents found to have been affected by the deficient practice:The most recent roommate change for Resident #90 was on 9/3/13. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action (s) will be taken:The Social Service Director has been re-educated related to the standard of notification and documentation of room or roommate changes. What measures will be put into place or what systematic changes will be made to ensure that the deficient	01/18/2014

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	During an interview on 12/13/2013 at 10:46 A.M., Resident #90 indicated she had had several roommate changes and was not provided notice to the roomate change. She stated, "They just bring them in." During an interview on 12/18/13 at 9:15 A.M., the Administrator indicated documentation was not available which indicated Resident #90 received notice prior to her roommate moving into her room. She indicated it was the facility's protocol to inform residents of room status changes and to document the notification in the resident's record. 3.1-3(v)(2)		practice does not recur:The Social Service Director has been re-educated related to the standard of notification and documentation of room or roommate changes. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:A notification Quality Assurance Performance Improvement audit tool will be utilized weekly times 4 weeks, then bi-weekly times 4 weeks, and then monthly until the alleged deficient practice does not recur.The Quality Assurance Performance Improvement interview tool will be reviewed in the monthly Quality Assurance Performance Improvement meeting by the Quality Assurance Performance Improvement committee.	
F000279 SS=G	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.			

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	The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). Based on observation, record review, and interview, the facility failed to develop a plan of care for pressure areas with interventions to promote healing which resulted in harm to a resident as evidenced by a stage I pressure area increasing to a stage III pressure area. This deficient practice affected 1 of 1 residents reviewed for the development of care plans for pressure areas (Resident #11). Findings: During an observation of wound care on 12/18/2013 at 9:57 A.M., Resident #11 was observed to have a circular shaped stage III open area to his left buttock. Resident #11's record was reviewed on 12/17/2013 at 9:52 A.M. Resident #11 had diagnoses which included but were not limited to, dementia, multiple sclerosis, congestive heart failure, and a history of pressure areas.	F000279	Develop Comprehensive Care PlansIt is the practice of the provider to use the results of the assessment to develop, review, and revise the resident's comprehensive plan of care.This provider is respectively requesting an Informal Dispute Resolution review to focus on the scope and severity for this citation, as the documentation does not support the allegation that Resident #11 experienced actual harm. The pressure area was identified on 11/20/13. The physician was immediately notified and a new treatment order was obtained and implemented. There is documentation on the Medication Administration Record to support that the treatment was consistently applied per the physician's order. The documentation in the Nursing Note, Medication Administration Record, and Weekly Skin Integrity Review (all entered on 11/20/13) reflect that there was an "open area". This documentation does not support the allegation that the pressure area progressed from a Stage I to a Stage III. What	01/18/2014

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	The record lacked documentation of a care plan which addressed Resident #11's history of pressure areas. An untimed nurse's note dated 11/20/2013, indicated, "CNA [Certified Nursing Assistant] reported small open area with slight redness to coccyx/sacral. Physician office notified n/o [new order] for EPC [cream] q [every] shift." The record lacked documentation of the wound, peri-wound, or the stage of the wound. An untimed physician's order dated 12/4/2013, indicated the physician ordered a special mattress to be placed on Resident #11's bed, Resident #11 was to remain in his bed except for meals, and a special cushion [roho] was to be placed in his recliner. The record indicated a care plan was not immediately developed when the open area was noted. A wound evaluation flow sheet dated 12/4/2013, indicated Resident #11's pressure area was staged at a stage 3, measured 1.8 centimeters [cm] in length, 1.4 cm in width, and 0.3 cm in depth, had a scant amount of serous exudates, the wound bed had 100 percent granulation,		corrective actions will be accomplished for those residents found to have been affected by the deficient practice:Resident # 11's plan of care has been reviewed/revised. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action (s) will be taken:The plan of care for residents with pressure sores have been reviewed/revised. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:The licensed nursing staff have been re-educated on the provider's protocols for communication of, and Care Plan development for, any change in skin condition.The Unit Manager or her designee will audit the new orders and clinical status change log daily to assist with compliance with proper Care Plan development for any changes in skin condition.How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:A skin condition Quality Assurance Performance Improvement audit tool will be utilized weekly times 4 weeks, then bi-weekly times 4 weeks, and then monthly until the alleged deficient practice does not recur.The Quality Assurance Performance Improvement audit	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	the periwound was red, and the surrounding tissue was red/pink. A wound care evaluation flow sheet dated 12/7/2013, indicated Resident #11's wound improved slightly with measurements of 1.8 cm length, 1.2 cm width, and 0.2 cm depth. During an interview on 12/18/2013 at 11:16 A.M., the Administrator indicated the nurse who discovered the pressure wound failed to document it on the twenty-four hour report. The Administrator indicated there was a delay in notifying the wound care nurse and a delay in developing and implementing interventions in a care plan to facilitate wound healing. During an interview on 12/19/2013 at 9:47 A.M., the facility's wound nurse indicated he was not notified of Resident #11's pressure wound until 12/4/2013. He indicated the area had previously been open and indicted he would have aggressively treated the area if he had been notified of the area when it was discovered on 11/20/13. He indicated as soon as he found out about the wound he immediately contacted the doctor and obtained orders to change his mattress to a low air loss mattress and implemented the roho cushion in his recliner. The		tool will be reviewed in the monthly Quality Assurance Performance Improvement meeting by the Quality Assurance Performance Improvement	

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	155505	A. BUILDING 00 B. WING	12/19/2013

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	facility's wound care nurse stated, "He did not have the special mattress or the roho cushion in his recliner until I saw him." During a telephone interview on 12/19/2013 at 10:24 A.M., Licensed Practical Nurse [LPN] #1 indicated she was the nurse who first noted the open area. She stated, "He had a little spot so I called the doctor.... I am not a wound nurse and I don't know a lot about wounds.... I should have put it on the 24 hour report sheet but I didn't...." A document dated 2010, and titled "Pressure Ulcers/Skin Breakdown-Clinical Protocol" identified as a current facility policy by the Administrator on 12/18/2013 at 1:27 P.M., indicated, "...Assessment and Recognition...the nurse shall assess and document/report the following...full assessment of pressure sore including location, stage, length, width, and depth, presence of exudates or necrotic tissue... The physician will help the staff review and modify the care plan as appropriate, especially when... new wounds develop despite existing interventions...." 3.1-35(a)			

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F000314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. Based on observation, record review, and interview, the facility failed to ensure residents with pressure sores received prompt necessary treatment and services to promote healing which resulted in harm to a resident as evidenced by a stage I pressure area increasing to a stage III pressure area. This deficient practice affected 1 of 1 residents reviewed with pressure areas greater than stage 2 (Resident #11). Findings include: During an observation of wound care on 12/18/2013 at 9:57 A.M., Resident #11 was observed to have a circular shaped	F000314	Treatment/Services to Prevent/Heal Pressure SoresIt is the practice of the provider to ensure that each resident receives treatment/services for pressure sores to promote healing, prevent infection, and prevent new sores from developing. This provider is respectfully requesting an Informal Dispute Resolution review as the documentation does not support the allegation that Resident #11 experienced actual harm. The documentation does support that Resident #11 received prompt necessary treatment and services to promote healing. The pressure area was identified on 11/20/13. The physician was immediately	01/18/2014

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	stage III open area to his left buttock. Resident #11's record was reviewed on 12/17/2013 at 9:52 A.M. Resident #11 had diagnoses which included but were not limited to, dementia, multiple sclerosis, congestive heart failure, and a history of pressure areas. The record lacked documentation of a care plan which addressed Resident #11's history of pressure areas. An untimed nurse's note dated 11/20/2013, indicated, "CNA [Certified Nursing Assistant] reported small open area with slight redness to coccyx/sacral. Physician office notified n/o [new order] for EPC [cream] q [every] shift." The record lacked documentation of the wound, peri-wound, or the stage of the wound. An untimed physician's order dated 12/4/2013, indicated the physician ordered a special mattress to be placed on Resident #11's bed, Resident #11 was to remain in his bed except for meals, and a special cushion [roho] was to be placed in his recliner. The record indicated a care plan was not immediately developed when the open		notified on 11/20/13 and a new treatment order was obtained and implemented. There is documentation on the Medication Administration Record to support that the treatment was consistently applied per the physician's order. The documentation in the Nursing Note, Medication Administration Record, and the Weekly Skin Integrity Review (all entered on 11/20/13) reflect that there was an "open area"; this would not be considered a Stage I pressure area according to standard of practice. This documentation does not support the allegation that the pressure area progressed from a Stage I to a Stage III. In addition, the documentation supports that the provider had preventative measures in place as appropriate for this at-risk resident. The Medication Administration Record indicates that pressure reducing surfaces were in place in the bed and the wheelchair, he was also receiving nutritional supplements as recommended by the Registered Dietician. The documentation also supports that the nursing department was monitoring the resident's skin on a routine basis and new treatment was implemented at the time that the open area was identified. What corrective actions will be accomplished for those residents found to have been affected by the deficient	

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	area was noted and did not indicate a care plan for preventing pressure ulcers prior to 12/4/13. A wound evaluation flow sheet dated 12/4/2013, indicated Resident #11's pressure area was staged at a stage 3, measured 1.8 centimeters [cm] in length, 1.4 cm in width, and 0.3 cm in depth, had a scant amount of serous exudates, the wound bed had 100 percent granulation, the periwound was red, and the surrounding tissue was red/pink. A wound care evaluation flow sheet dated 12/7/2013, indicated Resident #11's wound had improved slightly with measurements of 1.8 cm length, 1.2 cm width, and 0.2 cm depth. During an interview on 12/18/2013 at 11:16 A.M., the Administrator indicated the nurse who discovered the pressure wound failed to document it on the twenty-four hour report. The Administrator indicated there was a delay in notifying the wound care nurse and a delay in developing and implementing interventions in a care plan to facilitate wound healing. During an interview on 12/19/2013 at 9:47 A.M., the facility's wound nurse indicated he was not notified of Resident		practice:Resident #11 pressure sore was assessed by the physician on 12/6/13 with new orders implemented. The wound is being monitored per the provider's protocols. How other residents having the potential to be effected by the same deficient practice will be identified and what corrective actions will be taken:Residents with pressure sores are being followed perthe provider's protocols. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:The licensed nursing staff have been re-educated on the provider's protocols for communication of changes in skin condition.The DON or designee will audit the wound report weekly to assist with compliance of treatment/services to promote wound healing.How the corrective action (s) will be monitored to ensure deficient practice will not recur, i.e., what quality assurance program will be put into place:A new skin condition Quality Assurance Performance Improvement audit tool will be utilized weekly times 4 weeks, then bi-weekly times 4 weeks and then monthly until the alleged deficient practice does not recur.The Quality Assurance Performance Improvement audits will be reviewed in the monthly Quality Assurance Performance Improvement meetings by the	

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	#11's pressure wound until 12/4/2013. He indicated the area had previously been open and indicted he would have aggressively treated the area if he had been notified of the area when it was discovered on 11/20/13. He indicated as soon as he found out about the wound he immediately contacted the doctor and obtained orders to change his mattress to a low air loss mattress and implemented the roho cushion in his recliner. The facility's wound care nurse stated, "He did not have the special mattress or the roho cushion in his recliner until I saw him." During a telephone interview on 12/19/2013 at 10:24 A.M., Licensed Practical Nurse [LPN] #1 indicated she was the nurse who first noted the open area. She stated, "He had a little spot so I called the doctor.... I am not a wound nurse and I don't know a lot about wounds.... I should have put it on the 24 hour report sheet but I didn't...." A document dated 2010, and titled "Pressure Ulcers/Skin Breakdown-Clinical Protocol" identified as a current facility policy by the Administrator on 12/18/2013 at 1:27 P.M., indicated, "...Assessment and Recognition...the nurse shall assess and document/report the following...full		Quality Assurance Performance Improvement committee.	

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	assessment of pressure sore including location, stage, length, width, and depth, presence of exudates or necrotic tissue... The physician will help the staff review and modify the care plan as appropriate, especially when... new wounds develop despite existing interventions...." 3.1-40(a)(2)			
F000329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any			

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	combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. Based on record review and interview, the facility failed to ensure behavior interventions were attempted prior to administering PRN [as needed] anti-psychotic medications. This deficient practice affected 1 of 5 residents reviewed for unnecessary medications (Resident #116). Findings include: Resident #116's record was reviewed on 12/16/13 at 12:10 P.M. Resident #116 had diagnoses which included, but were not limited to, Alzheimer's dementia, depression, and seizure disorder. An untimed physician's order dated 8/7/13, indicated, "Haldol [anti-psychotic medication] 0.5 mg [milligrams] tablet by mouth every 6 hours as needed times 2 weeks and then discontinue for agitation."	F000329	Drug Regimen is Free From Unnecessary DrugsIt is the practice of the provider to ensure that each resident's drug regimen is free from unnecessary drugs.What corrective actions will be accomplished for those residents found to have been affected by the deficient practice:The licensed nursing staff have been re-educated on the provider's protocols for administration and documentation of use of as-needed psychotropic medication. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:The licensed nursing staff have been re-educated on the provider's protocols for administration and documentation on the use of as-needed psychotropic medication. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does	01/18/2014

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	The MAR [medication administration record] dated August 2013, indicated Resident #116 was administered the PRN [as needed] Haldol thirteen times from 8/10/2013 through 8/19/2013. A document titled "Daily Skilled Nurse's Note", dated 8/10/13 through 8/19/13 indicated no behaviors were observed. On 8/11/13 through 8/19/13 hand written nursing notes had no indication of redirection or non-pharmacological interventions before the administration of Haldol. A care plan dated 8/12/13, indicated Resident #116 had a problem with restlessness as evidenced by he would not remain in his wheelchair and he became agitated and combative when redirected. Non pharmacological interventions indicated staff would ask him to be seated, advise him of potential for falls, assist to bathroom, and approach calmly. The record lacked documentation non pharmacological interventions were attempted prior to the administration of the PRN antipsychotic medication. During an interview on 12/17/13 at 1:15 P.M., with the Administrator and the Assistant Director of Nursing [ADON]		not recur:The licensed nursing staff have been re-educated on the provider's protocols for administration and documentation on the use of as-needed psychotropic medication. How the corrective action(s) will be monitored to ensure that the deficient practice will not recur, i.e., what quality assurance program will be put into place:An as-needed psychotropic medication Quality Assurance Performance Improvement tool will be utilized weekly times 4 weeks, then bi-weekly times 4 weeks, and then monthly until the alleged deficient practice does not recur.The Quality Assurance Performance Improvement audits will be reviewed in the monthly Quality Assurance Performance Improvement meetings by the Quality Assurance Performance Improvement committee.	

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	present, the Administrator indicated Resident #116 was admitted with orders for the PRN Haldol [anti-psychotic] medication. She further indicated the Haldol was used because Resident #116 had a behavior of "attempting to get up out of his chair." She indicated if staff tried to prevent him from standing he became " combative." The administrator indicated documentation was not available which indicated non-pharmacological interventions were consistently attempted prior to each administration of the PRN Haldol. A policy dated 2005, and titled "antipsychotic Drugs" identified as current by the Administrator on 12/19/2013 at 10:34 A.M., indicated, "...AS NEEDED or P.R.N. Antipsychotic Drugs should only be used when the resident has a specific condition for which antipsychotic drugs are indicated...The as needed or P.R.N. dose is being used to manage unexpected harmful behaviors that cannot be managed without antipsychotic drugs...." 3.1-48(a)(4) 3.1-48(b)(2)			
F000364 SS=D	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility			

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	provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. Based on observation, interview, and record review, the facility failed to ensure food was served at proper temperatures. This deficient practice affected 2 of 8 residents reviewed for food quality (Resident #39, and Resident #90). Findings include: During an observation on 12/18/2013 at 12:33 P.M., with the Administrator and Dietary staff #8 present, dietary staff #8 took the temperature of food prepared for a resident. The temperatures were: Chicken pot pie-100 degrees, wax beans-80 degrees, potatoes-80 degrees. During an interview on 12/13/2013 at 10:32 A.M., Resident #90 indicated the facility food was not served at proper temperatures. She stated, "...it is either warm or cold but seldom hot...." During an interview on 12/13/2013 at 2:13 P.M., Resident #39 indicated the food was not served at proper temperatures. He stated, "Sometimes coffee is cold. Sometimes food is cold but by the time I get somebody to warm it up it has really gotten cold and by then I have lost my appetite..."	F000364	Nutritive Value/Appearance, Palatable/Prefer TemperaturesIt is the practice of the provider to serve meals to the residents that are prepared by methods that conserve nutritive values, flavor, and appearance, and that is palatable, attractive, and at the proper temperature.What corrective actions will be accomplished for those residents found to have been affected by the deficient practice:The Dietary and Nursing Departments have modified the processes of preparation and delivery of room tray service to assist with compliance of maintaining temperatures within acceptable standards (which are 140 degrees or abovefor hot foods and 40 degrees or below for cold foods) when served to the individual residents. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action (s) will be taken:The Dietary and Nursing Departments have modified the processes of preparation and delivery of room tray service to assist with the compliance of maintaining temperatures within acceptable standards (which are 140 degrees or above for hot foods and 40 degrees or below for cold foods) when served to the	01/18/2014

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	During an interview on 12/18/2013 at 12:40 P.M., Dietary staff #8 indicated the chicken pot pie temperature should have been 145 to 160 degrees, the wax beans and the potatoes should have been 140 degrees. An undated policy titled "Food Temperatures" identified as current by Dietary Staff #8 on 12/18/2013 at 1:00 P.M., indicated, "...Foods should be served at proper temperature to insure food safety and palatability.... Appropriate serving temperatures are: ... casseroles equal to or greater than 140 degrees but preferable 140 to 165 degrees F [Fahrenheit]... potatoes equal to or greater than 140 degrees but preferably 140-165 F...Vegetables equal to or greater than 140 degrees but preferably 140-165 F...." 3.1-21(a)(2)		individual residents. How measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur:The Dietary and Nursing Departments have modified the processes of preparation and delivery of room tray service to assist with the compliance of maintaining temperatures within acceptable standards by changing the transporting, holding, and delivery of food. Dietary staff will be in-serviced on the correct temperature ranges and protocols to keep temperatures within the appropriate ranges. How the corrective action(s) will be monitored to ensure deficient practice will not recur, i.e., what quality assurance programs will be put into place.A room tray Quality Assurance Performance Improvement audit tool will be utilized weekly times 4 weeks, then bi-weekly times 4 weeks, and then monthly until the alleged deficient practice does not recur. The Quality Assurance Performance Improvement audits will be reviewed in the monthly Quality Assurance Performance Improvement meetings by the Quality Assurance Performance Improvementcommittee.	